111TH CONGRESS
1ST SESSION

S. 1114

To establish a demonstration project to provide for patient-centered medical homes to improve the effectiveness and efficiency in providing medical assistance under the Medicaid program and child health assistance under the State Children's Health Insurance Program.

IN THE SENATE OF THE UNITED STATES

MAY 20, 2009

Mr. DURBIN (for himself and Mr. BURR) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To establish a demonstration project to provide for patient-centered medical homes to improve the effectiveness and efficiency in providing medical assistance under the Medicaid program and child health assistance under the State Children's Health Insurance Program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medical Homes Act of 2009''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Medical homes provide patient-centered care, leading to better health outcomes and greater patient satisfaction. A growing body of research supports the need to involve patients and their families in their own health care decisions, to better inform them of their treatment options, and to improve their access to information.

(2) Medical homes help patients better manage chronic diseases and maintain basic preventive care, resulting in better health outcomes than those who lack medical homes. An investigation of the Chronic Care Model discovered that the medical home reduced the risk of cardiovascular disease in diabetes patients, helped congestive heart failure patients become more knowledgeable and stay on recommended therapy, and increased the likelihood that asthma and diabetes patients would receive appropriate therapy.

(3) Medical homes also reduce disparities in access to care. A survey conducted by the Commonwealth Fund found that 74 percent of adults with a medical home have reliable access to the care they need, compared with only 52 percent of adults with a regular provider that is not a medical home and

38 percent of adults without any regular source of care or provider.

(4) Medical homes reduce racial and ethnic differences in access to medical care. Three-fourths of Caucasians, African Americans, and Hispanics with medical homes report getting care when they need it.

(5) Medical homes reduce duplicative health services and inappropriate emergency room use. In 1998, North Carolina launched the Community Care of North Carolina (CCNC) program, which employs the medical home concept. Presently, CCNC has developed 14 regional networks that include all of the Federally qualified health centers in the State and cover 740,000 recipients. An analysis conducted by Mercer Human Resources Consulting Group found that CCNC resulted in $244,000,000 in savings to the Medicaid program in 2004, with similar results in 2005 and 2006.

(6) Health information technology is a crucial foundation for medical homes. While many doctors' offices use electronic health records for billing or other administrative functions, few practices utilize health information technology systematically to measure and improve the quality of care they provide. For example, electronic health records can gen-

erate reports to ensure that all patients with chronic conditions receive recommended tests and are on target to meet their treatment goals. Computerized ordering systems, particularly with decision-support tools, can prevent medical and medication errors, while e-mail and interactive Internet websites can facilitate communication between patients and providers and improve patient education.

SEC. 3. MEDICAID AND CHIP DEMONSTRATION PROJECT TO SUPPORT PATIENT-CENTERED PRIMARY CARE.

(a) DEFINITIONS.—In this section:

(1) CARE MANAGEMENT MODEL.—The term ''care management model'' means a model that—

(A) uses health information technology and other innovations such as the chronic care model, to improve the management and coordination of care provided to patients;

(B) is centered on the relationship between a patient and their personal primary care provider;

(C) seeks guidance from—

(i) a steering committee; and

(ii) a medical management committee; and

(D) has established, where practicable, effective referral relationships between the primary care provider and the major medical specialties and ancillary services in the region.

(2) HEALTH CENTER.—The term ''health center'' has the meaning given that term in section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a)).

(3) MEDICAID.—The term ''Medicaid'' means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(4) MEDICAL MANAGEMENT COMMITTEE.—The term ''medical management committee'' means a group of practitioners that—

(A) provides services in the community in which the practice or health center is located;

(B) reviews evidence-based practice guidelines;

(C) selects targeted disease and care processes that address health conditions in the community (as identified in the National or State health assessment or as outlined in ''Healthy People 2010'', or any subsequent similar report (as determined by the Secretary));

(D) defines programs to target disease and care processes;

(E) establishes standards and measures for patient-centered medical homes, taking into account nationally-developed standards and measures; and

(F) makes the determination described in subparagraph (A)(iii) of paragraph (5), taking into account the considerations under subparagraph (B) of such paragraph.

(5) PATIENT-CENTERED MEDICAL HOME.—

(A) IN GENERAL.—The term ''patient-centered medical home'' means a physician-directed practice or a health center that—

(i) incorporates the attributes of the care management model described in paragraph (1);

(ii) voluntarily participates in an independent evaluation process whereby primary care providers submit information to the medical management committee of the relevant network;

(iii) the medical management committee determines has the capability to achieve improvements in the management

and coordination of care for targeted beneficiaries (as defined by statewide quality improvement standards and outcomes); and

(iv) meets the requirements imposed on a covered entity for purposes of applying part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) and all regulatory provisions promulgated thereunder, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(B) CONSIDERATIONS.—In making the determination under subparagraph (A)(iii), the medical management committee shall consider the following:

(i) ACCESS AND COMMUNICATION WITH PATIENTS.—Whether the practice or health center applies both standards for access to care for, and standards for communication with, targeted beneficiaries who

receive care through the practice or health center.

(ii) MANAGING PATIENT INFORMATION AND USING INFORMATION MANAGEMENT TO SUPPORT PATIENT CARE.—Whether the practice or health center has readily accessible, clinically useful information on such beneficiaries that enables the practice or health center to provide comprehensive and systematic treatment.

(iii) MANAGING AND COORDINATING CARE ACCORDING TO INDIVIDUAL NEEDS.—Whether the practice or health center—

(I) maintains continuous relationships with such beneficiaries by implementing evidence-based guidelines and applying such guidelines to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries;

(II) assists in the early identification of health care needs;

(III) provides ongoing primary care;

(IV) coordinates with a broad range of other specialty, ancillary, and related services; and

(V) provides health care services and consultations in a culturally and linguistically appropriate manner, as well as at a time and location that is convenient to the patient.

(iv) PROVIDING ONGOING ASSISTANCE AND ENCOURAGEMENT IN PATIENT SELF-MANAGEMENT.—Whether the practice or health center—

(I) collaborates with targeted beneficiaries who receive care through the practice or health center to pursue their goals for optimal achievable health;

(II) assesses patient-specific barriers; and

(III) conducts activities to support patient self-management.

(v) RESOURCES TO MANAGE CARE.—Whether the practice or health center has in place the resources and processes necessary to achieve improvements in the

management and coordination of care for targeted beneficiaries who receive care through the practice or health center.

(vi) MONITORING PERFORMANCE.—Whether the practice or health center—

(I) monitors its clinical process and performance (including process and outcome measures) in meeting the applicable standards under paragraph (4)(E); and

(II) provides information in a form and manner specified by the steering committee and medical management committee with respect to such process and performance.

(6) PERSONAL PRIMARY CARE PROVIDER.—The term ''personal primary care provider'' means—

(A) a physician, nurse practitioner, or other qualified health care provider (as determined by the Secretary), who—

(i) practices in a patient-centered medical home; and

(ii) has been trained to provide first contact, continuous, and comprehensive care for the whole person, not limited to a

specific disease condition or organ system, including care for all types of health conditions (such as acute care, chronic care, and preventive services); or

(B) a health center that—

(i) is a patient-centered medical home; and

(ii) has providers on staff that have received the training described in subparagraph (A)(ii).

(7) PRIMARY CARE CASE MANAGEMENT SERVICES; PRIMARY CARE CASE MANAGER.—The terms ''primary care case management services'' and ''primary care case manager'' have the meaning given those terms in section 1905(t) of the Social Security Act (42 U.S.C. 1396d(t)).

(8) PROJECT.—The term ''project'' means the demonstration project established under this section.

(9) CHIP.—The term ''CHIP'' means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396aa et seq.).

(10) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(11) STEERING COMMITTEE.—The term ''steering committee'' means a local management group comprised of collaborating local health care practitioners or a local not-for-profit network of health care practitioners—

(A) that implements State-level initiatives;

(B) that develops local improvement initiatives;

(C) whose mission is to—

(i) investigate questions related to community-based practice; and

(ii) improve the quality of primary care; and

(D) whose membership—

(i) represents the health care delivery system of the community it serves; and

(ii) includes physicians (with an emphasis on primary care physicians) and at least 1 representative from each part of the collaborative or network (such as a representative from a health center, a representative from the health department, a representative from social services, and a representative from each public and private

hospital in the collaborative or the network).

(12) TARGETED BENEFICIARY.—

(A) IN GENERAL.—The term ''targeted beneficiary'' means an individual who is eligible for benefits under a State plan under Medicaid or a State child health plan under CHIP.

(B) PARTICIPATION IN PATIENT-CENTERED MEDICAL HOME.—Individuals who are eligible for benefits under Medicaid or CHIP in a State that has been selected to participate in the project shall receive care through a patient-centered medical home when available.

(C) ENSURING CHOICE.—In the case of such an individual who receives care through a patient-centered medical home, the individual shall receive guidance from their personal primary care provider on appropriate referrals to other health care professionals in the context of shared decision-making.

(b) ESTABLISHMENT.—The Secretary shall establish a demonstration project under Medicaid and CHIP for the implementation of a patient-centered medical home program that meets the requirements of subsection (d) to improve the effectiveness and efficiency in providing medical

assistance under Medicaid and CHIP to an estimated 500,000 to 1,000,000 targeted beneficiaries.

(c) PROJECT DESIGN.—

(1) DURATION.—The project shall be conducted for a 3-year period, beginning not later than [October 1, 2011].

(2) SITES.—

(A) IN GENERAL.—The project shall be conducted in 8 States—

(i) four of which already provide medical assistance under Medicaid for primary care case management services as of the date of enactment of this Act; and

(ii) four of which do not provide such medical assistance.

(B) APPLICATION.—A State seeking to participate in the project shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(C) SELECTION.—In selecting States to participate in the project, the Secretary shall ensure that urban, rural, and underserved areas are served by the project.

(3) GRANTS AND PAYMENTS.—

(A) DEVELOPMENT GRANTS.—

(i) FIRST YEAR DEVELOPMENT GRANTS.—The Secretary shall award development grants to States participating in the project during the first year the project is conducted. Grants awarded under this clause shall be used by a participating State to—

(I) assist with the development of steering committees, medical management committees, and local networks of health care providers; and

(II) facilitate coordination with local communities to be better prepared and positioned to understand and meet the needs of the communities served by patient-centered medical homes.

(ii) SECOND YEAR FUNDING.—The Secretary shall award additional grant funds to States that received a development grant under clause (i) during the second year the project is conducted if the Secretary determines such funds are necessary to ensure continued participation in

the project by the State. Grant funds awarded under this clause shall be used by a participating State to assist in making the payments described in paragraph (B). To the extent a State uses such grant funds for such purpose, no matching payment may be made to the State for the payments made with such funds under section 1903(a) or 2105(a) of the Social Security Act (42 U.S.C. 1396b(a); 1397ee(a)).

(B) ADDITIONAL PAYMENTS TO PERSONAL PRIMARY CARE PROVIDERS AND STEERING COMMITTEES.—

(i) PAYMENTS TO PERSONAL PRIMARY CARE PROVIDERS.—

(I) IN GENERAL.—Subject to subsection (d)(6)(B), a State participating in the project shall pay a personal primary care provider not less than $2.50 per month per targeted beneficiary assigned to the personal primary care provider, regardless of whether the provider saw the targeted beneficiary that month.

(II) FEDERAL MATCHING PAYMENT.—Subject to subparagraph (A)(ii), amounts paid to a personal primary care provider under subclause (I) shall be considered medical assistance or child health assistance for purposes of section 1903(a) or 2105(a), respectively, of the Social Security Act (42 U.S.C. 1396b(a); 1397ee(a)).

(III) PATIENT POPULATION.—In determining the amount of payment to a personal primary care provider per month with respect to targeted beneficiaries under this clause, a State participating in the project shall take into account the care needs of such targeted beneficiaries.

(ii) PAYMENTS TO STEERING COMMITTEES.—

(I) IN GENERAL.—Subject to subsection (d)(6)(B), a State participating in the project shall pay a steering committee not less than $2.50 per targeted beneficiary per month.

(II) FEDERAL MATCHING PAYMENT.—Subject to subparagraph (A)(ii), amounts paid to a steering committee under subclause (I) shall be considered medical assistance or child health assistance for purposes of section 1903(a) or 2105(a), respectively, of the Social Security Act (42 U.S.C. 1396b(a); 1397ee(a)).

(III) USE OF FUNDS.—Amounts paid to a steering committee under subclause (I) shall be used (in accordance with any applicable Medicaid requirements) to purchase health information technology, pay primary care case managers, support network initiatives, and for such other uses as the steering committee determines appropriate.

(4) TECHNICAL ASSISTANCE.—The Secretary shall make available technical assistance to States, physician practices, and health centers participating in the project during the duration of the project.

(5) BEST PRACTICES INFORMATION.—The Secretary shall collect and make available to States par-

ticipating in the project information on best practices for patient-centered medical homes.

(d) PATIENT-CENTERED MEDICAL HOME PROGRAM.—

(1) IN GENERAL.—For purposes of this section, a patient-centered medical home program meets the requirements of this subsection if, under such program, targeted beneficiaries have access to a personal primary care provider in a patient-centered medical home as their source of first contact, comprehensive, and coordinated care for the whole person.

(2) ELEMENTS.—

(A) MANDATORY ELEMENTS.—

(i) IN GENERAL.—Such program shall include the following elements:

(I) A steering committee.

(II) A medical management committee.

(III) A network of physician practices and health centers that have volunteered to participate as patient-centered medical homes to provide high-quality care, focusing on preven-

tive care, at the appropriate time and place and in a cost-effective manner.

(IV) Hospitals and local public health departments that will work in cooperation with the network of patient-centered medical homes to coordinate and provide health care.

(V) Primary care case managers to assist with care coordination.

(VI) Health information technology to facilitate the provision and coordination of health care by network participants.

(ii) MULTIPLE LOCATIONS IN THE STATE.—In the case where a State operates a patient-centered medical home program in 2 or more areas in the State, the program in each of those areas shall include the elements described in clause (i).

(B) OPTIONAL ELEMENTS.—Such program may include a non-profit organization that—

(i) includes a steering committee and a medical management committee; and

(ii) manages the payments to steering committees described in subsection (c)(3)(B)(ii).

(3) GOALS.—Such program shall be designed—

(A) to increase—

(i) cost efficiencies of health care delivery;

(ii) access to appropriate health care services, especially wellness and prevention care, at times convenient for patients;

(iii) patient satisfaction;

(iv) communication among primary care providers, hospitals, and other health care providers;

(v) school attendance; and

(vi) the quality of health care services (as determined by the relevant steering committee and medical management committee, taking into account nationally developed standards and measures); and

(B) to decrease—

(i) inappropriate emergency room utilization, which can be accomplished through initiatives, such as expanded hours of care throughout the program network;

(ii) avoidable hospitalizations; and

(iii) duplication of health care services provided.

(4) PAYMENT.—Under the program, payment shall be provided to personal primary care providers and steering committees (in accordance with subsection (c)(3)(B)).

(5) NOTIFICATION.—The State shall notify individuals enrolled in Medicaid or CHIP about—

(A) the patient-centered medical home program;

(B) the providers participating in such program; and

(C) the benefits of such program.

(6) TREATMENT OF STATES WITH A MANAGED CARE CONTRACT.—

(A) IN GENERAL.—In the case where a State contracts with a private entity to manage parts of the State Medicaid program, the State shall—

(i) ensure that the private entity follows the care management model; and

(ii) establish a medical management committee and a steering committee in the community.

(B) ADJUSTMENT OF PAYMENT AMOUNTS.—The State may adjust the amount of payments made under (c)(3)(B), taking into consideration the management role carried out by the private entity described in subparagraph (A) and the cost effectiveness provided by such entity in certain areas, such as health information technology.

(e) EVALUATION AND PROJECT REPORT.—

(1) IN GENERAL.—

(A) EVALUATION.—The Secretary, in consultation with appropriate health care professional associations, shall evaluate the project in order to determine the effectiveness of patient-centered medical homes in terms of quality improvement, patient and provider satisfaction, and the improvement of health outcomes.

(B) PROJECT REPORT.—Not later than 12 months after completion of the project, the Secretary shall submit to Congress a report on the project containing the results of the evaluation conducted under subparagraph (A). Such report shall include—

(i) an assessment of the differences, if any, between the quality of the care pro-

vided through the patient-centered medical home program conducted under the project in the States that provided medical assistance for primary care case management services and those that did not;

(ii) an assessment of quality improvements and clinical outcomes as a result of such program;

(iii) estimates of cost savings resulting from such program; and

(iv) recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(2) SENSE OF THE SENATE.—It is the sense of the Senate that titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 1397aa et seq.) should be amended, based on the results of the evaluation and report under paragraph (1), to establish a patient-centered medical home program under such titles on a permanent basis.

(f) WAIVER.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall waive compliance with such requirements of titles XI, XIX, and XXI of the Social Security Act (42 U.S.C. 1301 et seq.; 1396 et seq.;

1397aa et seq.) to the extent and for the period the Secretary finds necessary to conduct the project.

(2) LIMITATION.—In no case shall the Secretary waive compliance with the requirements of subsections (a)(10)(A), (a)(15), and (bb) of section 1902 of the Social Security Act (42 U.S.C. 1396a) under paragraph (1), to the extent that such requirements require the provision of and reimbursement for services described in section 1905(a)(2)(C) of such Act (42 U.S.C. 1396d(a)(2)(C)).

○